No. 2
—1/47
5-17-39

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 40256

FILED NOV 28 1947 318

Registration District No.

Primary Registration District No. 1003

Registrar's No. 10445

1. PLACE OF DEATH:

(a) County

(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Mo. Baptist Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether

In this community
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County

(c) City or town Springfield
(If outside city or town limits, write "RURAL")

(d) Street No. 1423 Sherman Ave.
(If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Sadie Thomason

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex female

5. Color or race white

6. (a) Single, widowed, married, divorced single

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive years

7. Birth date of deceased Dec. (Month) 29 (Day) 1902 (Year)

8. AGE:

Years	Months	Days	If less than one day
44	10	13	hr. min.

9. Birthplace Paragould (City, town, or county) Ark. (State or foreign country)

10. Usual occupation Home

11. Industry or business

FATHER

12. Name L. P. Thomason

13. Birthplace (City, town, or county) Ark. (State or foreign country)

MOTHER

14. Maiden name Olivia Cobb

15. Birthplace (City, town, or county) Ark. (State or foreign country)

16. (a) Informant L. P. Thomason

(b) Address Springfield Mo.

17. (a) removal (Burial, cremation, or removal) (b) Date thereof 11-13-47 (Month) (Day) (Year)

(c) Place: burial or cremation Springfield Mo.

18. (a) Signature of funeral director Drehmann-Harral

(b) Address 1905 Union Blvd.

19. (a) NOV 13 1947 (Date received local registrar) (b) J. F. Brenck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 12 year 1947 hour 9 minute A. M.

21. I hereby certify that I attended the deceased from Aug. 1947 to 11/12 1947 that I last saw her alive on 11/12/47 19 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Acute Myocarditis	4 day
Due to: Lobar Pneumonia	15 days
Due to: Articular Rheumatism	2 yrs
Chr. tonsillitis	
Other conditions: acute Nephritis (Include pregnancy within 3 months of death)	3 day
Major findings: Of operations: Chronic tonsillitis	
Of autopsy	

PHYSICIAN

Underline the cause of which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)

While at work? (e) Means of injury

23. Signature Charles W. Harris M.D. (M. D. or other)

Address 5298a Page Date signed 11/12/47

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

RAIL-WAY

Jefferson City Printing Co.

(Licensed Embalmer's Statement on Reverse Side)

1 to 4

10.15

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

..... Registered Apprentice No.....,

working under my personal supervision.

Signed Warren A. Carver

Licensed Embalmer No. 3534

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.